MISSOURI MEDICAID

Revised 12/02/2005

DRUG PRIOR AUTHORIZATION POLICY

This site contains policy sheets for each of the categories of drugs prior authorized through the Missouri Medicaid Drug Prior Authorization Process. Please be aware that these policies are dynamic and will be revised as frequently as necessary to remain consistent with changes in state policy and evidence based medical standards. Documents on this site may not be the most current reflection of policy. For verification of current policy, please contact the Pharmacy Helpdesk at 800-392-8030.

These documents are not to be used as drug prior authorization request forms, but may be printed and used as a guide when submitting written requests on the Drug Prior Authorization Request Form by mail to the address on the form, by fax at 573-636-6470 or when calling the Drug Prior Authorization hotline at 800-392-8030.

Drug prior authorization requests are individually reviewed and approvals granted on a case-by-case basis, as submitted information/documentation warrants. Additional information may be requested of the prescriber in order to complete the review of a drug prior authorization request, should the information/documentation initially submitted be unclear or insufficient.

All requests for drug prior authorization must be initiated by a physician or other authorized prescriber, such as dentist or advanced practice nurse, with prescribing authority for the drug category for which prior authorization is being requested. Requests received with insufficient information for review or received from an individual other than an authorized prescriber will not initiate a prior authorization review nor the 24-hour response period.

Continued

MISSOURI MEDICAID DRUG PRIOR AUTHORIZATION PROCESS

Antifungal Products Request – Required Information

Effective 3-3-04

The information must be provided to enable us to process your Drug Prior Authorization request for an oral antifungal. Please complete a drug prior authorization form including this information and submit to the address or FAX specified on the form.

IF USED AS AN ATTACHMENT TO A DRUG PRIOR AUTHORIZATION REQUEST, PLEASE BE SURE ALL INFORMATION IS SUPPLIED AND IS LEGIBLE TO ASSURE ACCURATE AND TIMELY PROCESSING. ILLEGIBLE FORMS SUBMITTED WILL BE DENIED OR RETURNED TO THE REQUESTOR.

Patient Information: Patient Name, Medicaid number (DCN) and date of birth

Drug name (trade and generic), strength, dosage formulation, and directions.

Planned therapy protocol and length of therapy anticipated.

Anatomic location of infection.

Method by which diagnosis was established and date performed: KOH microscopic exam, Fungal culture, or nail biopsy.

Percentage of nail plate involvement.

Current serum ALT and AST results and date performed.

Current serum creatinine clearance result and date performed.

If contraindication for oral antifungal therapy, specify contraindication.

Documentation of individual performing monthly nail removal.

If history of left ventricular dysfunction, specify diagnosis.

Please be aware that Missouri Medicaid does not pay for cosmetic product use.

Written requests must include **original** signature of requesting physician or APN. Prescriber address, telephone and FAX number is also essential.

MISSOURI MEDICAID DRUG PRIOR AUTHORIZATION PROCESS
Modafanil (Provigil®) Request - Required Information
Revision 1-16-02

The information must be provided to enable us to process your Drug Prior Authorization request for modafanil (Provigil®). Please complete a drug prior authorization form including this information and submit to the address or FAX specified on the form.

IF USED AS AN ATTACHMENT TO A DRUG PRIOR AUTHORIZATION REQUEST, PLEASE BE SURE ALL INFORMATION IS SUPPLIED AND IS LEGIBLE TO ASSURE ACCURATE PROCESSING. ILLEGIBLE FORMS WILL BE DENIED OR RETURNED TO THE REQUESTOR.

Patient information: Patient Name, Medicaid number (DCN) and date of birth

Drug strength requested and directions for use.

Diagnosis for use.

If the patient has been previously stabilized with the use of any other medication, provide the medication used and its effectiveness.

Report any history of drug abuse or note absence of drug abuse.

If thyroid function has been evaluated, report test performed and the results.

A copy of the results of the Mini mental status exam may be requested by state staff to establish treatment efficacy related to approved medical treatment.

A copy of the results of the Wechsler memory scale may be requested by state staff to establish treatment efficacy related to approved medical treatment.

A copy of the polysomnogram report and multiple sleep latency test report confirming diagnosis, date performed, and results may be requested by state staff to establish treatment efficacy related to approved medical treatment.

If indication for use is fatigue secondary to an autoimmune diagnosis, submit documentation of alternative drug therapy previously tried and failed as well as duration of use.

Please note unsigned transcriptions are preliminary reports and do not represent a medical or legal document. Medicaid requires validated reports signed by the physician. Electronically signed reports are acceptable.

PLEASE NOTE THAT OFFICE RECORD NOTES ALONE AND/OR CHART NOTATIONS WILL NOT SUFFICE FOR THE REQUIREMENT OF THOSE TEST REPORTS WHICH ARE NOT PERFORMED/INTERPRETED IN AN OFFICE SETTING.

Written requests must include original signature of requesting physician or APN. Prescriber address, telephone and FAX number information is also essential.

MISSOURI MEDICAID DRUG PRIOR AUTHORIZATION PROCESS

Topical Retinoid Products Request – Required Information

Effective 2-11-04

The information must be provided to enable our office to process your Drug Prior Authorization request for a topical retinoid product Please complete a drug prior authorization form including this information and submit to the address or FAX specified on the form.

IF USED AS AN ATTACHMENT TO A DRUG PRIOR AUTHORIZATION REQUEST, PLEASE BE SURE ALL INFORMATION IS SUPPLIED AND IS LEGIBLE TO ASSURE ACCURATE AND TIMELY PROCESSING. ILLEGIBLE FORMS SUBMITTED WILL BE DENIED OR RETURNED TO THE REQUESTOR.

Patient Information: Patient Name, Medicaid number (DCN) and date of birth

Drug name (trade and generic), strength, formulation, dosing directions.

Diagnosis for which use is indicated.

Dates of documented trial/failure with benzoyl peroxide product.

Name and strength of benzoyl peroxide produce used.

Documentation, if applicable, of an adverse drug event to a retinoic acid product.

Name of retinoic acid product and documented dates of the product use.

Reason retinoic acid product was discontinued.

Please be aware that Missouri Medicaid does not pay for cosmetic product use.

Written requests must include **original** signature of requesting physician or APN. Prescriber address, telephone, and FAX number information is also essential.

MISSOURI MEDICAID DRUG PRIOR AUTHORIZATION PROCESS
Trade Name Drug Request - Required Information
Revision 1-16-02

The information must be provided to enable us to process your Drug Prior Authorization request for trade name drug. Please complete a drug prior authorization form including this information and submit to the address or FAX specified on the form.

IF USED AS AN ATTACHMENT TO A DRUG PRIOR AUTHORIZATION REQUEST, PLEASE BE SURE ALL INFORMATION IS SUPPLIED AND IS LEGIBLE TO ASSURE ACCURATE PROCESSING. ILLEGIBLE FORMS WILL BE DENIED OR RETURNED TO THE REQUESTOR.

Patient information: Patient Name
Patient Medicaid Number (DCN)
Patient date of birth

Name of the specific drug being requested, dosage form (capsule, tablet, packet, etc.) strength, and directions for use.

Diagnosis for use.

Document when the generic was tried and how long the trial period was. If no trial, provide the medical justification for brand name use.

Specify the medical problem caused by the generic product. Describe the medical problem in detail.
allergy
adverse reaction
poor disease control
other

Documentation of a MedWatch report filed with the FDA. A copy must accompany the prior authorization request. A copy may be downloaded at http://www.fda.gov/medwatch/safety/3500.pdf**.**

Office progress notes documenting failure of generic may be requested by state staff to establish treatment efficacy.

PLEASE NOTE THAT OFFICE RECORD NOTES ALONE AND/OR CHART NOTATIONS WILL NOT SUFFICE FOR THE REQUIREMENT OF THOSE TEST REPORTS WHICH ARE NOT PERFORMED/INTERPRETED IN AN OFFICE SETTING.

Written requests must include original signature of requesting physician or APN. Prescriber address, telephone and FAX number information is also essential.

MISSOURI MEDICAID DRUG PRIOR AUTHORIZATION PROCESS
Sildenafil Citrate (Viagra®) Request - Required Information
Revision 1-16-02

Rescinded 12-01-05. See http://dss.missouri.gov/dms/pharmacy/pdf/druglist.pdf for listing of drug excluded from coverage

The information must be provided to enable us to process your Drug Prior Authorization request for sildenafil citrate (Viagra®). Please complete a drug prior authorization form including this information and submit to the address or FAX specified on the form.

IF USED AS AN ATTACHMENT TO A DRUG PRIOR AUTHORIZATION REQUEST, PLEASE BE SURE ALL INFORMATION IS SUPPLIED AND IS LEGIBLE TO ASSURE ACCURATE PROCESSING. ILLEGIBLE FORMS WILL BE DENIED OR RETURNED TO THE REQUESTOR.

Patient information: Patient Name
Patient Medicaid Number (DCN)
Patient date of birth

Document whether the impotence in this patient is equivalent to "Erectile Dysfunction".

Provide the differential (secondary) diagnosis.

Date patient received a COMPLETE physical exam including cardiovascular, genitourinary (GU), and neurological systems.

Document patient's complete medication regimen. Report any nitrate use or absence of use.

PLEASE NOTE THAT OFFICE RECORD NOTES ALONE AND/OR CHART NOTATIONS WILL NOT SUFFICE FOR THE REQUIREMENT OF THOSE TEST REPORTS WHICH ARE NOT PERFORMED/INTERPRETED IN AN OFFICE SETTING.

Written requests must include original signature of requesting physician or APN. Prescriber address, telephone and FAX number information is also essential.

Please note that approvals are limited to six (6) units per thirty (30) day period.

MISSOURI MEDICAID DRUG PRIOR AUTHORIZATION PROCESS
Orlistat (Xenical®) Request - Required Information
Revision 1-16-02

The information must be provided to enable us to process your Drug Prior Authorization request for orlistat (Xenical®). Please complete a drug prior authorization form including this information and submit to the address or FAX specified on the form.

IF USED AS AN ATTACHMENT TO A DRUG PRIOR AUTHORIZATION REQUEST, PLEASE BE SURE ALL INFORMATION IS SUPPLIED AND IS LEGIBLE TO ASSURE ACCURATE PROCESSING. ILLEGIBLE FORMS WILL BE DENIED OR RETURNED TO THE REQUESTOR.

Patient information: Patient Name
Patient Medicaid Number (DCN)
Patient date of birth

Diagnosis for use.

Baseline lipid profile must be performed and a copy FAXed to our office.

Documentation that all four lipid-lowering classes have been tried before Xenical is required.

Document the specific classes tried and order in which they were tried.

Trial of HMG CoA Reductase Inhibitors is required. Specify the two (2) statins used.

Trial of Bile Acid Sequestrants is required. Specify product used.

Trial of Fibric Acid Derivatives is required. Specify product used.

Trial of Niacin Products is required. Specify product used.

If a lipid-lowering class was not tried, specify medical rationale.

For each lipid-lowering class used, pre and post lipid profile reports must be provided.

PLEASE NOTE THAT OFFICE RECORD NOTES ALONE AND/OR CHART NOTATIONS WILL NOT SUFFICE FOR THE REQUIREMENT OF THOSE TEST REPORTS WHICH ARE NOT PERFORMED/INTERPRETED IN AN OFFICE SETTING.

Written requests must include original signature of requesting physician or APN. Prescriber address, telephone and FAX number information is also essential.

MISSOURI MEDICAID DRUG PRIOR AUTHORIZATION PROCESS
Alprostadil Request - Required Information
Revision 1-16-02
Rescinded 07-07-05. See http://dss.missouri.gov/dms/pharmacy/pdf/druglist.pdf for listing of drug excluded from coverage

The information must be provided to enable us to process your Drug Prior Authorization request for alprostadil (Muse®, Edex®, and Caverject®). Please complete a drug prior authorization form including this information and submit to the address or FAX specified on the form.

IF USED AS AN ATTACHMENT TO A DRUG PRIOR AUTHORIZATION REQUEST, PLEASE BE SURE ALL INFORMATION IS SUPPLIED AND IS LEGIBLE TO ASSURE ACCURATE PROCESSING. ILLEGIBLE FORMS WILL BE DENIED OR RETURNED TO THE REQUESTOR.

Patient information: Patient Name
Patient Medicaid Number (DCN)
Patient date of birth

Name of the specific drug being requested.

Dosage form (kit, vial, ampule or suppository), strength, and directions for use.

Diagnosis for use of the requested drug. Document whether this diagnosis is equivalent to erectile dysfunction.

Document if any of the following conditions are present: Sickle cell disease or trait, Multiple Myeloma, Leukemia, Thrombocythemia, a condition predisposing to priapism or an anatomical deformity of the penis.

Provide the differential (secondary) diagnosis.

The date of the last complete physical exam in the office (includes cardiovascular system assessment).

Whether an in-office trial dose was given to monitor for response and adverse effects.

Written requests must include original signature of requesting physician or APN. Prescriber address, telephone and FAX number information is also essential.
Please note that approvals are limited to six (6) units per thirty (30) day period.

MISSOURI MEDICAID DRUG PRIOR AUTHORIZATION PROCESS
Isotretinoin (Accutane®) Request - Required Information
Revision 1-18-05

The information must be provided to enable us to process your Drug Prior Authorization request for Isotretinoin (Accutane®). Please complete a drug prior authorization form including this information and submit to the address or FAX specified on the form.

IF USED AS AN ATTACHMENT TO A DRUG PRIOR AUTHORIZATION REQUEST, PLEASE BE SURE ALL INFORMATION IS SUPPLIED AND IS LEGIBLE TO ASSURE ACCURATE PROCESSING. ILLEGIBLE FORMS WILL BE DENIED OR RETURNED TO THE REQUESTOR.

Patient information: Patient Name
Patient Medicaid Number (DCN)
Patient date of birth

Diagnosis for use.

Drug strength , dosing schedule and directions for use.

If recipient is female, document that a serum pregnancy test is negative within the last two weeks and that a written consent form is on file.

Document the two forms of birth control that have been used for the most recent two months. If post-hysterectomy, provide the hysterectomy date.

Documentation that baseline labs of a lipid profile, CBC and liver function were performed.

If a 30-day trial has been completed, describe the response.

PLEASE NOTE THAT OFFICE RECORD NOTES ALONE AND/OR CHART NOTATIONS WILL NOT SUFFICE FOR THE REQUIREMENT OF THOSE TEST REPORTS WHICH ARE NOT PERFORMED/INTERPRETED IN AN OFFICE SETTING.

Written requests must include original signature of requesting physician or APN. Prescriber address, telephone and FAX number information is also essential.

MISSOURI MEDICAID DRUG PRIOR AUTHORIZATION PROCESS
New Drug Products - Required Information
Revision 8-01-02

The information must be provided to enable us to process your Drug Prior Authorization request for a new drug product. Please complete a drug prior authorization form including this information and submit to the address or FAX specified on the form.

IF USED AS AN ATTACHMENT TO A DRUG PRIOR AUTHORIZATION REQUEST, PLEASE BE SURE ALL INFORMATION IS SUPPLIED AND IS LEGIBLE TO ASSURE ACCURATE PROCESSING. ILLEGIBLE FORMS WILL BE DENIED OR RETURNED TO THE REQUESTOR.

Patient information: Patient Name, Medicaid number (DCN) and date of birth

Drug name (trade and generic), strength, dosage formulation, and directions for use.

Diagnosis for which use is indicated.

Written requests must include original signature of requesting prescriber. Prescriber address, telephone and FAX number information is also essential.

(Continued)

New Product Review Determinations/Continued Drug Prior Authorization Criteria

ACUFLEX® 635mg – 55mg Tablets

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access alternative product

ADOXA®

- Diagnosis consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

ALCORTIN® 2%-1%-1% packet
Effective 11/15/04, this product is no longer covered due to DESI status change

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

ALDURAZYME®

- Diagnosis consistent with FDA approved indication(s)

ALMOND OIL BITTER (PASTE)

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

AMEVIVE®

- Diagnosis of moderate – severe plaque psoriasis
- Adult age 21 or older
- Documented trial and failure with at least one open-access therapeutic class anti-psoriatic agent

Drug PA approvals in this category will be limited to a maximum of 90 days authorization period

ANIMI-3® 0.5-1-12.5mg CAPSULES

- Product use consistent with FDA approved indication(s)
- *Documented trial and failure with at least one prescription cholesterol-lowering agent in each therapeutic class or a contraindication to those agents*

AZASAN®

- Diagnosis consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

BREVIBLOC® 20 MG/ML VIAL
BREVIBLOC® 20 MG/ML IV SOLUTION

- Diagnosis consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

CALCIFOL® 500-1.6 MG WAFER

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access alternative product

CARBOHOL GEL®

- Product use consistent with FDA approved indications
- Documented trial and failure with at least one open-access therapeutic class equivalent product

CEREFOLIN® TABS

- Product use consistent with FDA approved indication(s).
- Documented trial and failure with at least one open-access therapeutic class equivalent product

CLINDAGEL® 1% gel

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

CLINDESSE® 2% CREAM

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

CLOBEX® LOTION
CLOBEX® 0.05% SHAMPOO

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

CORVITE®

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one prescription multivitamin containing 1 mg folic acid.

DARVOCET A500® TABS

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

DIGEX® 15-62.5 MG CAPSULE

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access antacid with simethicone AND one dicyclomine product used concurrently

DIHYDROERGOTAMINE 1 MG/ML VIAL

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

DOMPERIDONE®

- Product use consistent with FDA approved indications
- Documented trial and failure with at least one open-access therapeutic class equivalent product

DUOCAINE®

- Product use consistent with FDA approved indications

DURABAC® CAPSULES

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access alternative product

DYNACIN®

- Diagnosis consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

EVOCLIN 1% FOAM

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product.

FABRAZYME® 35 mg VIAL
FABRAZYME® 5 mg VIAL

- Diagnosis consistent with FDA approved indication(s)

FEMRING®

- Diagnosis consistent with FDA approved indication(s)
- Documented trial and failure with at least one open access alternative product

FINACEA®

- Diagnosis consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

FLEXERIL®

- Diagnosis consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

FLEXTRA® 425-45-35 CAPSULES

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access alternative product

FLOXIN® 0.30% DROPERETTE

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

FOLGARD OS® TABS

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one ingredient-equivalent open access prescription or over-the-counter product within the same therapeutic class

HALFLYTELY®

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class alternative product.

HEALON 5®

- Diagnosis consistent with FDA approved indication(s)

LIBRAX® 5-2.5 MG CAPSULE
Effective 10/06/05 this product is no longer covered due to DESI status change

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product.

LIDAMANTLE® 3% LOTION
LIDAMANTLE HC® 0.5%-3% LOTION

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product.

LIDOCAINE HC® 0.5-3% LOTION
LIDOCAINE HCl® 3% LOTION

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product.

LIMBREL® 250 MG CAPSULES

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access alternative product

MESNEX® ORAL TABLETS

- Diagnosis consistent with FDA approved indication(s)
- Documented current treatment with ifosfamide

NICOMIDE®

- Diagnosis consistent with FDA approved indication(s)
- Documented trial and failure with at least one decongestant/antihistamine agent and one analgesic product use concomitantly.

NOREL SR® 40-325-8 MG TABLET

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one decongestant/antihistamine agent and one analgesic product use concomitantly.

NOVACORT® 2%-1%-1% GEL

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

ORAMAGIC Rx®

- Diagnosis consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access alternative product

OVACE® 10% CREAM
OVACE® 10% FOAM
OVACE® 10%GEL

- Diagnosis consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

OXYTROL®

- Diagnosis consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

Drug PA approvals in this category will be a maximum of 8 patches per month

PAMINE FORTE® 5 MG TABS

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

PANIXINE® 125 MG DISSOLVE TABLETS
PANIXINE® 250 MG DISSOLVE TABLES

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with open-access cephelaxin suspension or capsules

PLEXION® 10-5% MEDICATED PAD

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class alternative product

PRIALT® 25 MCG/ML VIAL
PRIALT® 100 MCG/ML VIAL

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one systemic analgesic or intrathecal morphine sulfate

PROSED® EC TABLETS

- Product use consistent with FDA approved indications
- Documented trial and failure with at least one open-access therapeutic class equivalent product

RADIAPLEX®

- Diagnosis consistent with FDA approved indication(s)

REGENECARE®

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open access therapeutic class equivalent product.

RESPIRATORY AGENTS, COUGH, COLD, AND SINUS PRODUCTS:

- Diagnosis consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access prescription or over-the-counter product within the same therapeutic class

Drug PA approvals in this category will be a maximum of 30 days

RESTASIS®

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access alternative product

ROSAC® CREAM

- Diagnosis consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

ROSULA NS® 10-10% MEDICATED PAD

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class alternative product

ROZEX® 0.75%EMULSION

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

SELSEB 2.25% SHAMPOO

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product.

SYMAX DUOTAB® 0.375 MG TABLET MPHASE

- Product use consistent with FDA approved indications
- Documented trial and failure with at least one open-access therapeutic class equivalent product

TRIAZ® 6% PADS
TRIAZ® 9% PADS

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

UDAMIN® 2MG TABLET
UDAMIN® SP 1-320 MG TABLET

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class alternative product

UMECTA® 40% SUSPENSION

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class alternative product

URISYM® CAPSULE

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class alternative product

UTA®

- Diagnosis consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

VANACHOL® CAPSULE

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one prescription cholesterol-lowering agent in each therapeutic class or a contraindication to those agents.

VANOS® 0.1% CREAM

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open access therapeutic class alternative product

XIFAXAN® TABLET

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class alternative products

ZODERM® 4.5%-10% CLEANSER
ZODERM® 6.5%-10% CLEANSER
ZODERM® 8.5%-10% CLEANSER
ZODERM® 4.5%-10% CREAM
ZODERM® 6.5%-10% CREAM
ZODERM® 8.5%-10% CREAM
ZODERM® 4.5%-10% GEL
ZODERM® 6.5%-10% GEL
ZODERM® 8.5%-10% GEL

- Product use consistent with FDA approved indication(s)
- Documented trial and failure with at least one open-access therapeutic class equivalent product

MISSOURI MEDICAID DRUG PRIOR AUTHORIZATION PROCESS
Growth Hormone Request - Required Information
Effective 12-18-03

The information must be provided to enable us to process your Drug Prior Authorization request for a new drug product. Please complete a drug prior authorization form including this information and submit to the address or FAX specified on the form.

IF USED AS AN ATTACHMENT TO A DRUG PRIOR AUTHORIZATION REQUEST, PLEASE BE SURE ALL INFORMATION IS SUPPLIED AND IS LEGIBLE TO ASSURE ACCURATE PROCESSING. ILLEGIBLE FORMS WILL BE DENIED OR RETURNED TO THE REQUESTOR.

Patient information: Patient Name, Medicaid number (DCN) and date of birth

Drug name (trade and generic), strength, dosage formulation, and directions for use.

Diagnosis for which use is indicated.

For initial requests, name of growth hormone deficiency test performed in the last 2 years, date performed, and test results. For continued authorization after one year PA approval, GH testing results within the last 6 months including date of repeat testing.

If renal disease component, specify time frame of impairment and specific renal diagnosis. If transplant candidate or post-transplant, please advise.

If any of the following diagnoses are pertinent to patient's history please specify: Prader-Willi Syndrome, Turner Syndrome, Crohn's Disease, Cardiomyopathy, Short Bowel Syndrome, or other medically accepted uses.

For diagnosis of HIV with cachexia, provide baseline body weight, 2 week post-treatment initiation weight, and 10 or 12 week post-treatment initiation weight.

Written requests must include **original** signature of requesting physician or APN. Prescriber address, telephone and FAX number information is also essential.